Board of Directors Public

SUMMARY REPORT	Meeting Date:	28 July 2021
	Agenda Item:	14

Report Title:	**Clinical and Social Care Strategy**	
Author(s):	Dr Linda Wilkinson	
Accountable Director:	Dr Mike Hunter	
Other Meetings presented to or previously agreed at:	**Committee/Group:**	Trust Board
	Date:	26th May 2021
Key Points recommendations to or previously agreed at:	Trust Board requested a further update to the Clinical and Social Care Strategy following consultation on the draft strategy approved to go out for consultation by the Board on 26th May 2021.	

Summary of key points in report

The paper outlines a final version of the Clinical and Social Care Strategy for SHSC with a 5-year development plan based on key principles that were co-produced with service users and carers, staff and partners during the stakeholder engagement workshops. This includes care based on principles of **Person-Centred, Trauma-Informed, Evidence-Led and Strengths-Based** approaches**.**

The overarching aim of the strategy is to improve the quality of care received by our service users and to reduce health inequalities.

We have outlined a context that focuses on the delivery of mental health and social care in Primary Care, the City, and the Wider System building on strategic priorities below:

1. **What matters to people**: accessible primary and secondary care services, purposeful hospital admissions and minimal restrictive practice.
2. **Knowing we make a difference**: person centred outcome frameworks, digital systems to capture experiences and outcomes, measurable consistency, and continuity of care.
3. **Creating environments for excellence**: therapeutic built environments that support care models, accredited teams across services, quality networks throughout SHSC.
4. **Transforming care in Sheffield**: community partnerships for clinical, social care & academic excellence, all age integration of physical & mental health and social care, zero suicide Sheffield.
5. **Leading the system for outstanding care**: developing SYB quality networks for mental health, learning disability and autism; an equitable mental health and social care system; integrated care from neighbourhoods to system.

A draft strategy was produced in May 2021: following approval from the Trust Board, consultation and engagement meetings took place with stakeholders in June & July 2021 to “test out” and take feedback on the Clinical and Social Care Strategy. We wanted to ensure that service users, carers, staff, and partners felt that they could recognise and engage with the content of the strategy, make any changes based on the

feedback from the workshops and share ideas about the implementation plan.

The updated report shares the implementation plan in a high-level road map, which outlines the outcomes and the underpinning deliverables, including the supporting enabling strategies. The key implementation principle is to establish workstreams for **Person-Centred, Trauma-Informed, Evidence-Led and Strengths-Based** care that develop SHSC's capacity and capability across these areas and work alongside the enabling strategies.

We recognise that a key factor in the success of the strategy is the genuine coproduction from the conception throughout the 5-year implementation plan. The feedback we have received from service users, carers and staff is that the strategy is written in accessible language and is a representation of what service users, carers staff and partners have told us about the changes that they want to see and be a part of as the strategy moves towards the implementation plan.

Recommendation for the Board/Committee to consider:

Consider for Action		**Approval**	**X**	**Assurance**	**X**	**Information**	

Recommendation: The Board Committee is asked to approve the Clinical and Social Care Strategy.

Please identify which strategic priorities will be impacted by this report:				
Covid-19 Getting through safely	*Yes*	✓	*No*	
CQC Getting Back to Good	*Yes*	✓	*No*	
Transformation – Changing things that will make a difference	*Yes*	✓	*No*	
Partnerships – working together to make a bigger impact	*Yes*	✓	*No*	

Is this report relevant to compliance with any key standards ?					**State specific standard**
Care Quality Commission	*Yes*	✓	*No*		All CQC standards relate to the quality of care
IG Governance Toolkit	*Yes*		*No*	✓	

Have these areas been considered ? YES/NO					If Yes, what are the implications or the impact? If no, please explain why
Patient Safety and Experience	*Yes*	✓	*No*		Patient Safety and Experience is a key consideration within the Clinical and Social Care Strategy including a focus on the principles of Person-Centred, Trauma-Informed, Evidence-Led and Strengths-Based care.
Financial (revenue & capital)	*Yes*	✓	*No*		Finance is a core component of the Clinical and Social care Strategy, ensuring NHS Long Term Plan investment is used to enable evidence led care and demonstrable outcomes.
OD/Workforce	*Yes*	✓	*No*		OD and workforce considerations are explicitly part of the implementation plan – ensuring the change process is supported throughout the 5-year implementation plan.
Equality, Diversity & Inclusion	*Yes*	✓	*No*		EDI is referred to in relation to accessibility and workforce development ensuring the workforce is reflective of the Sheffield population.
Legal	*Yes*		*No*	✓	

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Clinical and Social Care Strategy

2021-2026

Proud to care in Sheffield

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Introduction

Welcome to the Strategy

Welcome to our Clinical and Social Care Strategy 2021-2026. This is the first time that Sheffield Health and Social Care (SHSC) has had a Clinical and Social Care Strategy, and the reason for developing the Strategy now is simple. In TeamSHSC we want everything we do to be led by providing the best specialist care to all the people we work with.

In bringing the Strategy together, we have involved service users and colleagues across SHSC and beyond, including Sheffield City Council, CCG, Healthwatch, Voluntary Care Sector and other health and social care providers in Sheffield. Working together to develop the Strategy is particularly important because Sheffield is an unequal city. We are amongst the most deprived local authorities in the country. People living in the most affluent parts of our city can typically expect to live eight years longer than those in the poorest areas. For people with mental health problems, learning disability and autism, inequalities are even more pronounced and often affect multiple aspects of their lives.

Our Strategy is focussed on reducing health inequalities, and we are committed to working with partners across the City to make Sheffield a healthier place for all to live.

Where are we now?

We have used a population health approach in combination with a Stakeholder analysis to develop a benchmark of where we are now in relation to mental health provision for the city. We recognise that learning disability and autism (LDA) and severe mental illness (SMI) such as psychosis, bipolar disorder, and complex trauma and “personality disorder” are closely associated with many forms of inequality including reduced life expectancy of up to 20 years when compared to the general population.

National Policy and key documents such as the NHS Long Term Plan have supported an understanding of the direction of travel in terms of the expected investments and improvements in mental health care. The White Paper “Integration and innovation: working together to improve health and social care for all” sets out proposals for strategic commissioning at the level of the South Yorkshire and Bassetlaw Integrated Care System (ICS), with system oversight of local services equipped to meet the needs of the people of Sheffield. What is clear is that the future direction will require us to work in different contexts: at the level of primary care networks, at the level of the City and at the level of the wider system in South Yorkshire and Bassetlaw. Within our Clinical and Social Care Strategy, we have drawn on the above principles to define a 5-year plan covering key priorities.

Where we want to get to?

Stakeholder workshops supported the understanding of where we are now and coproduced a shared vision of where we want to get to in improving the quality of care in our services. An outline of the detailed feedback from service users, carers, SHSC staff and our partners is detailed within the strategy.

The bedrock of our strategy is based on the values of SHSC and the recovery principle, delivering care that is Person-Centred, Strengths-Based, Evidence-Led and Trauma-Informed. In the strategy, we outline the model and present case examples of the impact of where we want to get to with our models of care, including how we will track service user recovery, learn from good practice, and practice-based evidence care, alongside understanding service user and carer experience.

We recognise that the changes we will implement need to follow the key deliverables outlined within the NHS Long Term Plan, meet the needs of service users and carers, commissioners, and partners

to deliver on the goal of improving quality and reducing health inequalities. The Clinical and Social Care Strategic 5 year plan encompasses this within the planning :

- **Understanding What Matters to People:** Improving the experience, safety, and quality of care for service users, carers and families through understanding what matters to people and co-producing systems and models of care.

- **Knowing We Make a Difference:** Seeking to help people to live well and reducing the inequalities associated with mental health problems and learning disability through early intervention, prevention and transformation of mental health care to be closer to communities and capturing impact and outcomes.

- **Creating Environments for Excellence:** Promoting the development of therapeutic teams through a well-trained workforce, working within with healing built-environments.

- **Transforming Care in Sheffield:** Building further and faster the partnerships and transformation with other organisations to become a more integrated health and social care system with improved outcomes, including a Zero Suicide ambition.

- **Leading the System for Outstanding Care:** Developing system quality networks for MHLDA and building an equitable system in South Yorkshire and Bassetlaw.

The themed feedback received from service users, carers and staff can be summarised as: "*the strategy is written in accessible easy to understand language":* it feels a good representation of what people have told us about the changes that they want to see: "*the 5 year staircase gives a good visual representation of the where we want to get to"* and the implementation plan with the workstreams explains the how this can be co-produced and delivered with service users, carers and staff. The detail can be found on pages 20-25 of the strategy.

How do we get there?

We have outlined an implementation plan, which explains how we will make the improvements working in partnership and valuing co-production to create the environments for great care and continuous improvement.

Our road map outlines the outcomes and the underpinning deliverables, including the supporting enabling strategies. We describe the relationship between the work of the Clinical and Social Care Strategy and the enabling strategies, and outline detail of the 5-year Transformation programme, giving information on how the enabling strategies will work to support the delivery of the Clinical and Social Care Strategy in a coordinated framework.

A detailed plan to define the initial programme implementation has been produced with a key milestones plan that can be found in Appendix 1 and Appendix 2

Summary

Throughout the development of the strategy the aim has been simple, to improve the quality of care that our service users receive at the same time as reducing health inequalities that adversely impact on many. In this Strategy, we present a 5-year plan for change. As we move forward with the work, we will continue to hold in mind what a privilege it is to work with people and help to make a difference in their lives.

The Clinical and Social Care Strategy Steering Group

Our Clinical and Social Care Strategy 2021/22 - 2025/26

Our Vision

To improve the mental, physical and social wellbeing of the people in our communities

Strategic aims

Deliver outstanding care **Create a great place to work** **Effective use of resources**

We will give care that is

- Person-Centred
- Evidence-Led
- Trauma-Informed
- Strength-Based

We will work with

- Primary Care
- The City
- The Wider System

What are we going to do?

- Develop Care Models that promote recovery

How will we do it?

- Design Services to meet people's needs
- Develop TeamSHSC

Sheffield and the Wider Mental Health Context

At SHSC we provide a wide range of specialist health and social care services to improve the mental, physical and social wellbeing of the people living in our communities. We want people to live fulfilled lives and aim to help them achieve this by providing services which work closely alongside primary care and services based within the community (e.g., voluntary sector, housing providers and local leaders) to meet people's health and social care needs, support their recovery and improve their health and wellbeing.

We recognise that learning disability and autism (LDA) and severe mental illness (SMI) such as psychosis, bipolar disorder, and complex trauma and "personality disorder" are closely associated with many forms of inequality including reduced life expectancy of up to 20 years when compared to the general population. Evidence suggests that the mortality gap is continuing to widen nationally. These inequalities are largely driven by complex and interrelated factors, including:

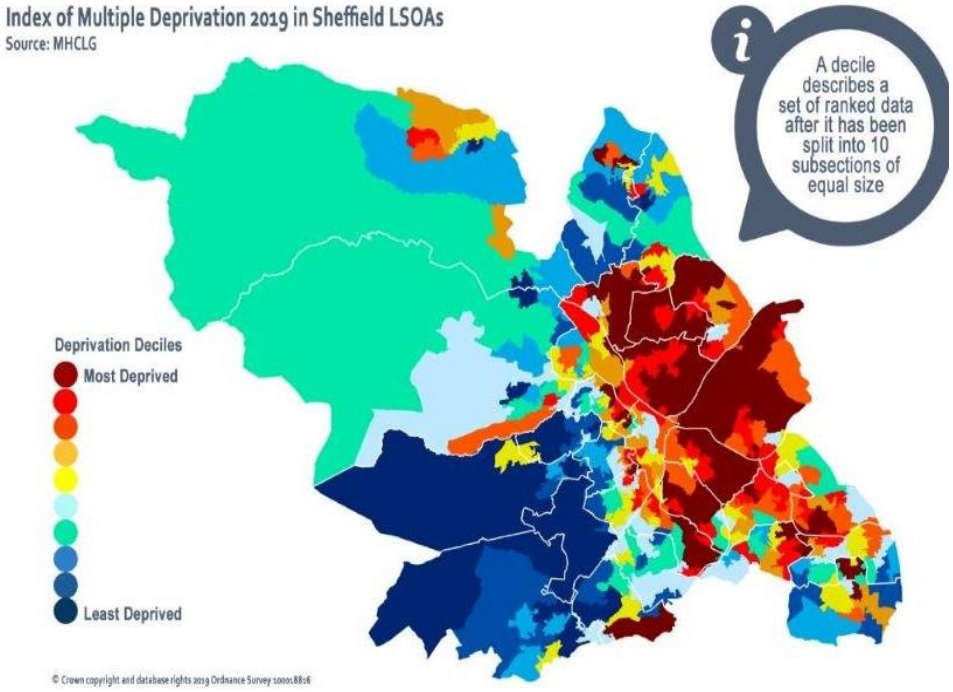
- Social and environmental determinants of poor health, including poverty, unemployment, and homelessness
- Stigma, discrimination, social isolation, and exclusion
- Increased levels of addictions including smoking, alcohol, and street drugs
- Lack of support to access health and preventative care
- Diagnostic overshadowing – seeing physical health symptoms as part of an existing mental health diagnosis, rather than as another physical health problem requiring treatment

We are aspiring to follow the key principles of good health and wellbeing following a population needs based model outlined in the diagram below.

Our Population

We know that people in poorer parts of Sheffield live shorter lives and have worse health than those in more affluent areas. We also see similar disparities affecting groups with specific shared characteristics, such as people from BAME backgrounds, or people with learning disabilities. These differences and disparities are the health inequalities that exist in our city, which we see as unacceptable.

Sheffield is an unequal city with an 8–10-year life expectancy gap between areas that fall within the 10% most deprived in the country (Burngreave, Firth Park, Southey, Manor Castle, and Park and Arbourthorne) and areas amongst the 1% most affluent in the UK (Fulwood, Ranmoor and Dore). We have a high concentration of people seeking asylum and refugee status living in the North of the city; a high population of people over the age of 65 years living in the South West of the city; and a high population of students living in the City centre. We recognise that "one size doesn't fit all" and our population requires different things of our services.



Sheffield is the seventh most deprived of England's eight core cities, with nearly a quarter of Sheffield's areas in the most deprived 10% nationally. Five areas in Sheffield are within the 1% most deprived in England, which is an increase from three in 2015 (Joint Strategic Needs Assessment 2019)

People with SMI and LDA experience a greater burden of physical health conditions, often driven by the inequalities that they face. It is estimated that two in three deaths for people with SMI are due to physical illnesses such as cardiovascular disease, which can be prevented.

In our current strategy we have been working to reduce inequalities through collaboration and integration of physical, mental health and social care. For example, by targeting improvements in the monitoring of physical health for our service users, running a Quit from smoking programme on our wards and implementing our Smokefree policy. We have expanded Early Intervention for Psychosis services and developed our Perinatal Mental Health service in line with the every child matters/giving the best start in life programmes. We recognise that we need to do more over the next five years to better meet the needs of people who use our services.

What has informed our Strategic thinking?

National Policy and Key Documents

There are several national documents that we have drawn on that set the national direction for services for people with mental health problems, learning disability and autism (MHLDA). These include No Health Without Physical & Mental Health; Longer, Healthier Lives; Zero Suicide; and NICE guidelines for mental health, learning disability and autism. The other key documents are the NHS Long Term Plan 2019, The Community Mental Health Framework for Adults and Older Adults 2019 and the recently published White Papers covering Reform of the Mental Health Act and Innovation and Integration (both 2021).

The NHS Long-Term Plan sets out a number of actions to improve detection and care for people with a range of physical and mental health problems, seeking to address health inequalities through the emphasis on early intervention, prevention and transformation of mental health care to be closer to communities with the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.

The Community Mental Health Framework describes how the Long-Term Plan's vision for a place-based community mental health model can be realised, and how community services should modernise to offer whole-person, whole-population health approaches, aligned with the new Primary Care Networks. The paper highlights how services have been fragmented over many years and must re-establish the original principles of community-based care with accessible services ('no wrong door'), integrated within the local communities.

The White Paper "Integration and innovation: working together to improve health and social care for all" sets out proposals for strategic commissioning at the level of the South Yorkshire and Bassetlaw Integrated Care System (ICS), with system oversight of local services equipped to meet the needs of the people of Sheffield.

What is clear is that the future direction will require us to work in different contexts: at the level of primary care networks, at the level of the City and at the level of the wider system in South Yorkshire and Bassetlaw.

Key Priorities

Within our Clinical and Social Care Strategy, we have drawn on the above principles of transformation around partnership working to define a 5-year plan covering key priorities listed below.

- **Understanding What Matters to People:** Improving the experience, safety, and quality of care for service users, carers and families through understanding what matters to people and co-producing systems and models of care.

- **Knowing We Make a Difference:** Seeking to help people to live well and reducing the inequalities associated with mental health problems and learning disability through early intervention, prevention and transformation of mental health care to be closer to communities and capturing impact and outcomes.

- **Creating Environments for Excellence:** Promoting the development of therapeutic teams through a well-trained workforce, working within with healing built-environments.

- **Transforming Care in Sheffield:** Building further and faster the partnerships and transformation with other organisations to become a more integrated health and social care system with improved outcomes, including a Zero Suicide ambition.

- **Leading the System for Outstanding Care:** Developing system quality networks for MHLDA and building an equitable system in South Yorkshire and Bassetlaw.

We will be developing more of our services within the local community, working in partnership with Primary Care, Local Authority and Voluntary Care Services, and re-establishing a Recovery College in order to deliver population based mental healthcare.

We want to offer more mental and social care in the least restrictive ways outside of a hospital care setting by building on the Primary Care Transformation project started last year. There will be further expansion of IAPT services for anxiety and depression alongside 10 specific physical health conditions including cancer, respiratory and cardiac conditions. The “At Risk Mental State” pathway is being established within the Early Intervention Services and the Assertive Outreach pathway is being re-established in the community services. Further development of the Complex Trauma / “Personality Disorder” pathways is being undertaken using the evidence-led Structured Clinical Management approach across teams. Crisis Services are being enhanced to 24/7 capacities.

Over the next two years we will see core Primary Care SMI mental health teams forming in each of the 15 Primary Care Networks that will function as multiagency, multidisciplinary teams being responsible for the mental healthcare for that population. As we start to increase the provision of care in the community, we are anticipating a reduction in the pressures on the hospital inpatient care due to the more robust provision in the community, early intervention, and the growing capacity to manage higher levels of acuity through the redesign and expansion of Core 24 crisis services and utilisation of the Crisis House and the Decision Unit.

Consultation with Stakeholders

How and whom we have consulted in relation to the Clinical and Social Care Strategy

The approach we took in creating this clinical strategy was to engage as widely as possible with service users, carers, staff, and partners to listen to experiences, gather ideas about improvements and priorities and bring people on board. Due to Covid restrictions much of the feedback was gathered through workshops led by experts by experience with senior leaders working with service users, carers, and staff working within SHSC and partner organisations.

We had an oversight group led by the Medical Director, consisting of an Expert by Experience, Clinical Directors from SHSC and Primary Care, Director of Strategy, Executive Director of Nursing and Professions/Chief Operating Officer and Heads of Professions, who all brought different expertise and experience.

In terms of engagement and coproduction, we held two workshops with service users and carers. Alongside this we met with Healthwatch Sheffield, whose role is to collect consumer feedback about health services in the city, and Sheffield Flourish, a charity that works collaboratively on innovative digital and community projects recognising the untapped strengths of people who have experienced mental health challenges. They work with service users to enable them to tell their stories.

We triangulated the feedback from a report written by Healthwatch Sheffield and Sheffield Flourish outlining the in-depth mental health journey for nine services users, with the noted findings and recommendations. We also triangulated feedback with the results of a questionnaire sent by HealthWatch to users of community mental health services in Sheffield.

We held 20 workshops, 14 of these were attended by approximately 400 staff that work across the 80 different teams within SHSC. We held a further six workshops with our partner organisations including representatives from 15 VCSE organisations, local Commissioners, Sheffield City Council, Sheffield Teaching and Sheffield Children's Hospital, Sheffield University, Sheffield Hallam University, Healthwatch, Sheffield Flourish and Public Health reaching over 90 stakeholders.

What is important to service users and carers?

Key messages from our services users and carers:
Access: they want services to have easy access, be based within the communities where people live, be responsive, coordinated and tailored to individual needs with a focus on overall wellbeing. The inclusion criteria for some services are too high. "*I felt I didn't have the right illness or are not ill enough"*

Early intervention: they want services to focus on early intervention support and signposting to stay well. "*I have to wait until I'm in a crisis before I get a response".*

When people need to come back into services following discharge, they want to *"find a way back into services without repeated assessments"*

Consistent Care: Sometimes there is discontinuity of care often due to staff turnover. *" [they] said they would hand my case over to the new person … But it didn't happen because of the covid and staffing"*

Service users and carers want continuity of care from clinicians and teams who they get to know and, if admitted to the inpatient wards, they want to spend as short a time as necessary in hospital with the least restrictive care, in therapeutic environments that support healing and recovery.

They want a skilled workforce that is representative of the community and able to provide culturally appropriate treatments. *"The white people's behaviour on the ward was passed off as passion and anxiety … I was labelled as angry, threatening, and aggressive".*

Partnership working: Service users want services to be delivered in good quality environments and have good partnerships with other services that can provide wrap around care with good communication between and within teams.

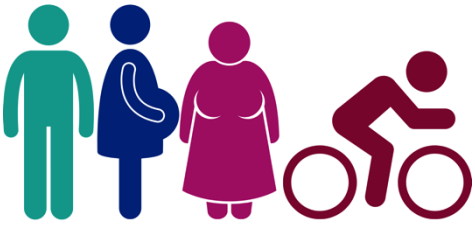
"I don't have to keep telling my story over and over again to different workers and different teams …"

Falling between the gaps: *"Difficulties being dropped in gaps and this is extremely detrimental to mental health as you feel you are being let down"*

Listen to me as an equal whole person: Service users and carers want to have an active role in their care, "feel fully informed and have a choice of treatments" and some people want to be involved in the delivery and running of the organisation.

Feedback indicates that service users want mental health services that understand inequality and the impacts of poverty on mental health. *"Services that can recognise the economic impacts of mental health problems offer additional support to those in financial hardship and have a role in connecting with community safety and cohesion".*

There were 173 responses to the Healthwatch survey, with the take home messages being that people who use services wanted an experience of care that was more caring, effective and responsive.



What is important to staff?

Triangulating feedback from staff in the latest staff survey results, with feedback in the engagement sessions as well as other key pieces of staff feedback from across the organisation, there are three key aspects that are important to staff that can be summarised as autonomy, belonging and contribution.

Providing excellent quality care to service users and their families is of paramount importance to staff. This inevitably draws on many aspects of organisational working. Innovation is key. Being able to initiate and follow through with quality improvements is essential, as well as having the opportunity to be able to participate in and influence decision making, at a local team level as well as more organisationally wide.

Staff felt: "Community teams are too small to effectively manage the increasing demand and the rising acuity levels which makes work stressful especially when managing clinical risk."

Being able to fully utilise skills and expertise, and receiving recognition for this, is fundamental. Staff feel strongly about maximising their contribution, as well as their associated personal development to deliver excellence.

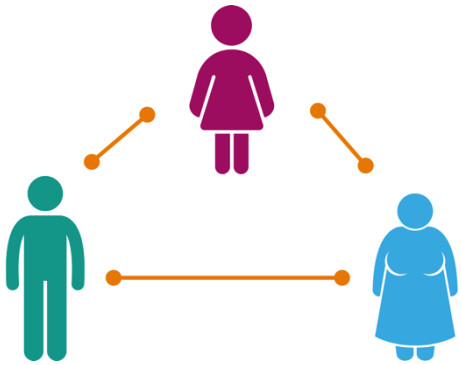
Staff felt "*Across teams the scope of what teams are expected to manage is increasing, this means that it feels difficult to fully utilise skills and expertise …lack of time to care…"*

Having good, respectful, and supportive relationships within teams and more widely across the Trust is not only valued but considered essential. Good connections between staff are recognised as often being the means by which high quality care is delivered, and complex problems managed or solved.

"Inconsistent workforce on the wards … bank and agency staff are helpful but not the same as a consistent team".

Good relationships across the organisation are fundamentally important: *"feeling listened to and getting feedback "*

Having the opportunity, support, and resources to develop, transform and deliver high quality services is fundamental to staff feeling valued, working optimally, and being fully engaged within the organisation. Devolved leadership is key, as is instilling a sense of optimism and hope.



What is important to our partners?

All organisations welcomed the opportunity to work in partnership to develop shared thinking about the strategy with more integrated work across mental health and social care *"Great to be asked and be involved from the beginning of the journey ... from conceptualisation of strategy to practical implementation of it rather than coming with the finished product."*

Our partners spoke about "handovers rather that handoffs", recognising that warm handovers with teams & systems where they come together to maintain shared responsibility across team and services until service users had settled into a new system was helpful to manage risk and safety for both service users and staff. "*It is often difficult to find the right person to speak to about access to mental health services."*

The workshops for some organisations provided the opportunity to "*heal past hurts … and the difficulties from the breakdown in relationships providing the platform for collaboration rather than competition*" working together to find ways of collaborating on bidding for funds, pooling and sharing knowledge and expertise to achieve better care for Sheffield citizens.

The VCSE sector reported experiencing some very good partnerships through the Primary Care Mental Health transformation programme of work and the Sheffield Psychology Board where "*SHSC services did not just parachute in and out of voluntary services but were building equal partnerships"* and developing long term relationships through shared contracts. This is working well through shared

values, principles and models of working, and changing the language and the skill sets of teams to improve the offer of services for people with complex problems. Although there are still reports of *"difficulties in communication because of pressure on time and incompatible digital systems."*

The junctions between internal teams and external partners can adversely affect the quality of experience for service users, result in disengagement, poor outcomes and at times harm. *"Clinical problems arise from teams not working in the interest of the [whole] pathway, sending people on the wrong path"*

Continuity of care: *"We have lost some aspects of continuity of care, for many of our service users their single experience of on-going or crisis mental health presentation is carved up by us into segments."*

Our service users often need groups of teams, statutory, voluntary, and peer-led, to work, prioritise, operationalize, care, and treat in unison across systems. *"Access to support can depend on where you are, which bit of the city. We need to be more consistent."*

Further Consultation on the Draft Strategy

A draft strategy was produced in May 2021: following approval from the Trust Board, consultation and engagement meetings took place with stakeholders in June and July to take feedback on the Clinical and Social Care Strategy. We wanted to "test out" the proposed strategy to ensure that service users, carers, staff, and partners felt that they could recognise and engage with the content of the strategy and make any changes based on the feedback from the twelve workshops. We recognise that a key factor in the success of the strategy is the genuine coproduction from the conception throughout the 5-year implementation plan.

Team SHSC workforce are our most important asset, we have people who are highly skilled and dedicated to mental healthcare. Therefore ensuring that the strategy aligns with what they want to achieve in individual teams alongside how this maps what service users, carers and partners tell us about the problems that we need to solve to meet their needs, is key to ensuring that we can be successful in embedding the strategy.

We ran 10 further workshops, which were attended by approximately 200 staff that work across different teams within SHSC. We held a further workshop with service users and a carer focus group, and a session with Sun-Rise. We ran a consultation session with Service User Governors and 2 workshops with our partner organisations, including representatives from VCSE organisations, local Commissioners, Sheffield City Council, Sheffield Teaching and Sheffield Children's Hospital, Sheffield University, Sheffield Hallam University, Healthwatch, Sheffield Flourish and Public Health reaching over 26 stakeholders.

All consulted felt that the strategy reflected what they had shared and what they identify as current challenges in terms of the core improvements that needed to be made within the clinical and social care pathways and our plan to initiate changes. The four cornerstones of care captured the recovery focus that service users and carers were looking for when they are engaging with the different services. They welcomed the plans to tackle access to services, being more consistent and working in partnership with other teams/organisations with smooth, warm handovers rather than "handoffs" and continuing to work with us in the coproduction framework.

Service users and staff welcomed the Trauma Informed care approach; all thought that we should be aware of the prevalence of traumatic events and the different ways that this can affect people who use and provide the service.

The Service user focus group talked about more specific ambitions for people with mental health problems within the city and wanted to see a focus in the detailed workstreams in the strategy that could tackle:

- Social isolation for adults, older adults, people with a learning disability and autism
- Helping people during times of crisis regain control of their life and putting in place tailored foundations to help prevent another crisis
- Having earlier access for people experiencing mental health conditions, to promote early intervention
- They wanted to see support for people with autism, and enhancing primary care mental health services
- Mobilise the community to report possible abuse and help protect people by connecting them to their communities.

Staff and partners reported seeing an outline of a 5-year plan that reflected some of the challenges and the ambitions helped to set a clear direction of what they could expect from the senior leadership group: what was expected of them in their day-to-day roles and the containment that this offered having a clear sense of purpose with all pulling in the same direction. Staff were keen to have space for reflection, to work with service users and their families with more of a proactive approach than "reacting to crisis".

Staff reported that the strategic 5-year plan helped to organise "what would happen when …rather than expecting something to change and not really understanding why it had not happened…clarity about holding others to account. "It's the first time I have ever seen clarity about how corporate services will be supporting clinical services with their enabling strategies mapping onto what we do clinically …"

Staff reported that the strategy brought together in one document all of the changes taking place across the Trust and it felt "weaved together …had coherence…was relatable".

Staff teams wanted to emphasise the pressure of the acuity and complexity within the clinical pathways and the need to have systems that are designed to better meet the needs of people using the service.

All of the people who attended the workshops were committed to leaning into the change, supporting, and being involved in the workstreams.

The themed feedback that we have had from service users, carers and staff can be summarised as: "*the strategy is written in accessible easy to understand language":* it feels a good representation of what people have told us about the changes that they want to see: "*the 5 year staircase gives a good visual representation of the where we want to get to"* and the implementation plan with the work streams explains the how this can be co-produced and delivered with service users, carers and staff.

The Foundations of Care

The bedrock of our strategy is based on the values of SHSC and the recovery principle, delivering care that is Person-Centred, Strengths-Based, Evidence-Led and Trauma-Informed.

"Recovery isn't about getting back to how you were before; it's about building something new." "Recovery is something you achieve for yourself. It is not something that someone else does for you, but others may be able to help if you want them to." (Rethink 2015)

Person-Centred

By being person-centred, we mean: Personalised Care to Support service users to live full and independent lives.

- Recognising that we are all unique, worthwhile individuals with equally unique experiences, personalities, beliefs, and values.
- Ensuring that people are given choices and supported to make informed decisions about what is important to them.
- Working with a core assumption of what is important to you is important to us.
- Empowering people so they can make as many decisions for themselves and to do as much for themselves, for as long as possible.
- Making sure that the needs of the individual come first.
- Accepting that we all need our own private space and time – and that services will respect this.
- Recognising that each person has human rights and that we will help ensure those rights are met and protected.
- Making decisions 'with' people, not 'for' people.

The process of recovery is different for each person and needs to be defined by him /her /they /them and seen in the context within they live. It involves the person learning to cope with features of their condition and moving towards increased wellness and meaningful activity.

It is important that TeamSHSC listens carefully to each person we work with and acknowledges differing views when these arise. Staff said, "Care plans should empower service users, encourage autonomy and independence, and be sensitive to their journey of recovery". Everyone told us how important it is for a care plan to be co-produced with the service user and their carer so that they are meaningful to them and promote personalised care.

Strengths-Based

By being strengths-based, we mean: Encourage use of personal resources, skills, abilities, knowledge & potential to protect choice and independence.

- Will provide care and support in a holistic, multidisciplinary, proportionate way.
- Will work with individuals in a way, which explores the person's abilities and circumstances rather than just focusing on 'what's wrong'.
- Will recognise that risk is part of everyday life for everyone. Risk will be looked at as an enabler and not as a barrier.
- Will help to reduce risks whilst at the same time supporting individuals to manage their own risks.
- Will support, and work with, people to identify how they can use their personal strengths and resources to move closer to how they want their life to be.
- Will provide the right amount of help, the right advice, at the right time.
- Will listen to how a person's illness, disability, social and personal situation impacts upon them.
- Will ask what matters to you, what is strong, and what is good?
- Will support you to be more engaged and involved in your local community.

Service users told us they want staff to talk to them about what and who is important to them. They want to be treated as a whole person, bearing in mind their culture and community. They want their care plan to be about them, not just their problems: "we want to be involved in the writing of it…nothing about me without me …. and ensure that the plan has a focus on strengths".

Supported self-management and social interventions are key components in care planning, using a strengths-based approach helps to facilitate discussions, which focus on the individual's abilities. For some of our services users, for example those with dementia, their strengths-based goals may be about maintaining independence and personal care. Involving carers and relatives in care planning, where appropriate, is important, increasingly so for those who irreversibly are losing their capacity to make decisions.

Evidence-Led

By being Evidence-Led, we mean: Using best available evidence to inform treatment plans.

- Provide services, which are based upon the best evidence available and best practice.
- Support and develop TeamSHSC by ensuring there is ready access to a range of resources where research and best practice can be found.
- Recognise that whilst evidence-based services are important, we will still value and respect each person as a unique individual. This means staff will be empowered to make decisions, guided by research and evidence but in a person-centred way.
- Acknowledge that evidence-based interventions are not only obtained from academics. We will seek out and listen to the views of service users, their family/carers about what has worked, and not worked, for them in the past.

The NICE guidelines provide high quality research-based evidence of interventions and best practice /practice-based evidence that clinical staff use to provide effective treatments. Service users and carers told us they want to be seen by a skilled person and offered a range of therapies. Staff said they want to be equipped with expert knowledge and skills, especially in talking therapies. They want services to be professional. Both staff and service users talked about the success of any intervention being dependent on the power of strong therapeutic relationship between service users and their clinicians.

Trauma-Informed

By being trauma-informed, SHSC will: Recognise & respond to trauma. Provide safe environments to take a strengths-based view: Build empowering relationships: Promote equality of access.

- Work to develop a trauma-informed system that asks about and understands the impacts of experiences including sexual, physical, and emotional abuse, and other trauma that impacts on mental health.
- Ask people who use our service "what happened to you?" rather than "what's wrong with you?"
- Train staff in trauma specific treatments with training that is coproduced by experts by experience and build a trauma-informed workforce.
- Prevent secondary trauma within staff by offering good support through supervision and reflective practice.
- Create safe physical and emotional healing environments where service users, carers, families, and staff receive and deliver care, and where there is least restrictive practice.
- Work to engage partner organisations to develop a citywide trauma-informed system.

Childhood adversity and trauma is now understood to be at the core of many mental health problems. A high percentage of people who use mental health services have experienced trauma, e.g., sexual, emotional, physical abuse: bullying and violence: loss of a parent: separation and family breakdown.

A trauma informed approach recognises the impact of traumatic events in the lives of people, it aims to provide environments where people feel safe enough to disclose what has happened to them, where they can expect staff to listen with compassion and respect, and where staff have the skills to validate and 'bear witness' to these events.

Trauma informed teams behave in ways that do not re-traumatise people, for example, knocking on a bedroom door and giving the person time to answer, or automatically offering people the choice of the gender of their worker where possible. This way of working recognises the importance of working collaboratively to enable service users to feel empowered and to build trust. They are also aware of the impact on staff of hearing stories of trauma and the importance of self-care. Service users talked about the importance of staff recognising compassion fatigue and wanted to ensure that staff had access to good support.

How will we know the strategy has had an impact?

We know having spoken to our service users, staff, partner agencies and commissioners that we are connected by a single aim of seeking to "improve the mental, physical and social wellbeing of the people in our communities." Our Clinical and Social Care Strategy has at its heart a stepped approach to delivering this vision together with those that use and provide our services.

How will we know if this has an impact?

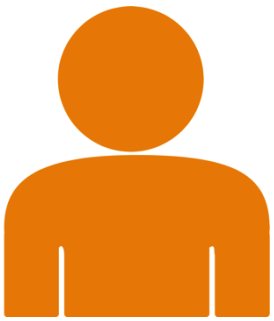
Across our organisation, every day that passes in every service we provide, there exists a rich tapestry of experiences of care received and delivered. We believe that there is learning form the experiences from our services users, staff and carers gives essential insight into the good care that is provided but also the gaps that sometimes exists between care as intended and care as experienced.

The following case-vignettes presented in this strategy cannot represent the rich and diverse set of experiences of all service users but are intended to tether the strategic aim with the lived experience of our service users, staff, and partners.

Case vignettes

There can be no single case vignette that reflects the experience of all our service users. We will work with teams to help them understand the experiences of people who use services, learning from excellence, incidents and near misses.

The cases below are composite and do not relate to specific service users, although the do illustrate key themes.



Vignette 1: Person-Centred

T is a 57-year-old man with a long history of mental health problems associated with bipolar affective disorder and alcohol dependency. T often presents in crisis following difficulties when he feels very low - at those times it is noted that he uses alcohol to manage distress and difficult feelings, which further exacerbates the crisis.

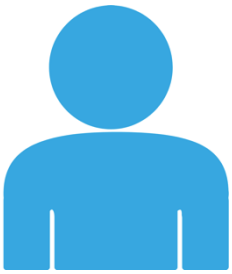
T is offered support during the crisis episodes; the team liaises regularly with family members and those supporting T during these periods. T's alcohol use is responded to appropriately by specialist services, and when presenting in crisis there is evidence of liaison with emergency services.

How would implementation of the core principles of the Strategy improve the care received by T?

Person-centred

There are up to four teams involved in T's care, and while each team works well with T, family members experience what for them appears uncoordinated care. The structure of services makes it harder to meet T's need from a person-centred point of view - the sum is not greater than the parts.

True person-centred care requires services to rethink the way in which care is accessed and provided. By beginning to re-design and deliver care through the person-centred lens, this Strategy provides us with an opportunity to better understand the potential gaps between services and embed approaches to organising care around the person at the centre, and their specific needs.



Vignette 2: Strengths-Based

Y is a 70-year-old and had been admitted to an older adult psychiatric ward following a serious suicide attempt. Y was treated for depression with medication but was still an in-patient some months later. Attempts to discharge Y were associated with serious self-harm. Although previously a highly sociable person, Y was in a state of withdrawal and frozen watchfulness.

One-to-one communication was difficult as Y offered monosyllabic answers, repetition of 'I don't know' and tendency to terminate interviews. Anxiety management and graded exposure to improve social skills proved ineffective because of difficulties in engaging Y meaningfully in the work. There were at times outbursts of anger and frustration if there were changes to ward routine.

Staff on the ward were finding it difficult to manage Y's needs to move forward with a care plan.

Strengths-Based

Therapy staff were introduced to working on the ward and the Staff team worked together to develop a broader understanding of Y, build up a strengths-based model and learn more of Y's interests and motivations. Behavioural observations with an assistant psychologist gave insight into an understanding of triggers for points of distress. Staff learned that Y would often behave in ways that brought particular interactions with the staff team. Through supervision staff were able to reflect on the interactions that they had with Y that initiated more of Y's strengths and interests rather than self-harm.

Y began to take more independent steps with self-care, feeling confident about leaving the ward for walks and periods of leave with family members, joining in with ward-based activities Y was interested in, Y's mood and motivation improved, and they were successfully discharged.

Vignette 3: Trauma-Informed

J is 35-year-old woman who frequently requires crisis intervention following self-harm.

J's childhood background was characterised by abuse, including neglect, verbal abuse, and physical assault over many years. As a child she tried to cope with the impact of the abuse by going through rituals such as counting and placing things in an order to get a sense of control and safety. These rituals carried through into teenage years and J would feel very distressed if unable to complete these

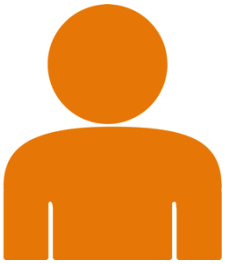
behaviours. This led to J being bullied at school and further problems developed around self-esteem and J began self-harming.

Trauma-Informed

The delivery of care in a trauma-informed way focuses on “what’s happened to you” and less on “what’s wrong with you “. It explains how trauma affects people's lives, their care needs and use of services.

Caring in a trauma-informed way supports a model of care that focuses on the development of collaborative and trusting relationships, and the importance of consistency across teams and services that leads to a whole system trauma-informed approach.

Trauma-informed care is defined as practices that promote a culture of safety, empowerment, and healing. Services and systems can understand about trauma and how it can affect people and groups, recognize the signs of trauma, and have a system that can respond to trauma. By achieving a trauma-informed approach to care, services can avoid re-traumatisation (e.g., restrictive practices) and provide improved outcomes for service users.



Vignette 4: Evidence-Led

B is a 24-year-old woman who gave birth to her daughter M two months ago. The health visitor is concerned about B who is reporting thoughts about death and dying. B had for the first 6-8 weeks been breastfeeding M but stopped when she started having thoughts that her breast milk was contaminated by substances and turning M into an alien.

B is becoming increasingly anxious and preoccupied about M’s development and her safety, and constantly checking M, for example waking her to check she is breathing. The health visitor has noted that M has lost weight and has stopped crying.

It is noted that B’s self-care is poor, she has not been getting dressed and she reports she is not sleeping. B feels that she has to hold M all the time, so that she feels safe and doesn’t cry.

In terms of the background, B is a single parent; her ex-partner did not want any involvement with the baby and has had no contact with B. In terms of support, B has distanced herself from family and friends, as she feels unable to share her thoughts and feelings, fearing that they would see her as a bad mother. It is clear that she has become very isolated.

Evidence-Led

There is overwhelming evidence that B requires specialist care from a specialist, multidisciplinary perinatal mental health team. She requires input from a range of professionals including psychologists, psychiatrists, and specialist nurses.

The team involved with B’s care will come together to look at an evidence-led approach. Elements of her care will include consideration of pharmacological treatments (noting risks around breast feeding) and interpersonal talking treatment, sitting alongside practical support from a parent-infant worker including baby massage and peer support to make progress.

The team will also use a new evidence-led treatment using video recordings of B with M to illustrate attachment and inform discussions around the mother/baby relationships with a parent/infant psychotherapist. Information from this will be utilised by the whole team to support B to recover from severe post-natal mental illness and form warm attachments with M that help to give her the best start in life.

Using outcome measures that matter to people

Service users and carers told us we should clearly articulate outcomes to demonstrate what is working well. We must be able to demonstrate that the evidence-based interventions we deliver are relevant and effective. Clinicians and service users said that using clinical outcomes is important, but that these must be more than just numbers; the data must be analysed and fed back to teams, service users and carers. The data should also form part of the Trust Board assurance process.

One of the measures of success of this Clinical and Social Care Strategy will be that our outcome measures demonstrate that service users' mental health, physical health and social wellbeing are improving. We need to demonstrate how insights gained from outcome measures reflect service users' needs and priorities are shaping our services.

TeamSHSC has chosen three outcome measures to monitor progress: ReQoL as a patient reported outcome measure, HoNOS as a clinician rated outcome measure and the Friend and Family Test (FFT) as a patient rated experience measure. We also have other specific outcome measures in use in a number of services such as the Patient Health Questionnaire (PHQ-9**)** a nine item self-report measure for assessing depression and the Generalized Anxiety Disorder (GAD-7) a seven item self-report measure of anxiety in our IAPT services.

We will develop our analytical framework for HoNOS, ReQoL and FFT to ensure that the results from these outcome measures will be included in our clinical dashboards, this will enable teams to see the impact of their interventions and adapt accordingly. Service users and carers will be able to see the effectiveness and responsiveness of services and the outcome data will inform service development and form part of our assurance processes.

We will develop systems and clinical practice where outcome measures are routinely used in sessions with service users to jointly monitor and share progress. Alongside this, we will use the outcome data to share practice-based evidence, understand the benefits of particular interventions and their effectiveness and share this learning across teams and contribute to the evidence-based learning/ research and publications.

Five-year strategic plan

We recognise that the changes we will implement need to follow the key deliverables outlined within the NHS Long Term Plan, meet the needs of service users and carers, commissioners and partners to deliver on the goal of improving quality and reducing health inequalities.

The figure below gives a high-level representation of the strategy, describing a summary of the five-year plan to build on each year a staircase platform of improvement in care that service users, carers and staff want to see. The fundamental principle is of care that is informed by the four pillars of person-centred, strengths-based, trauma-informed and evidence-led care, working in partnership across Primary Care, the City and the wider South Yorkshire Integrated Care System to increase quality and reduce inequalities.

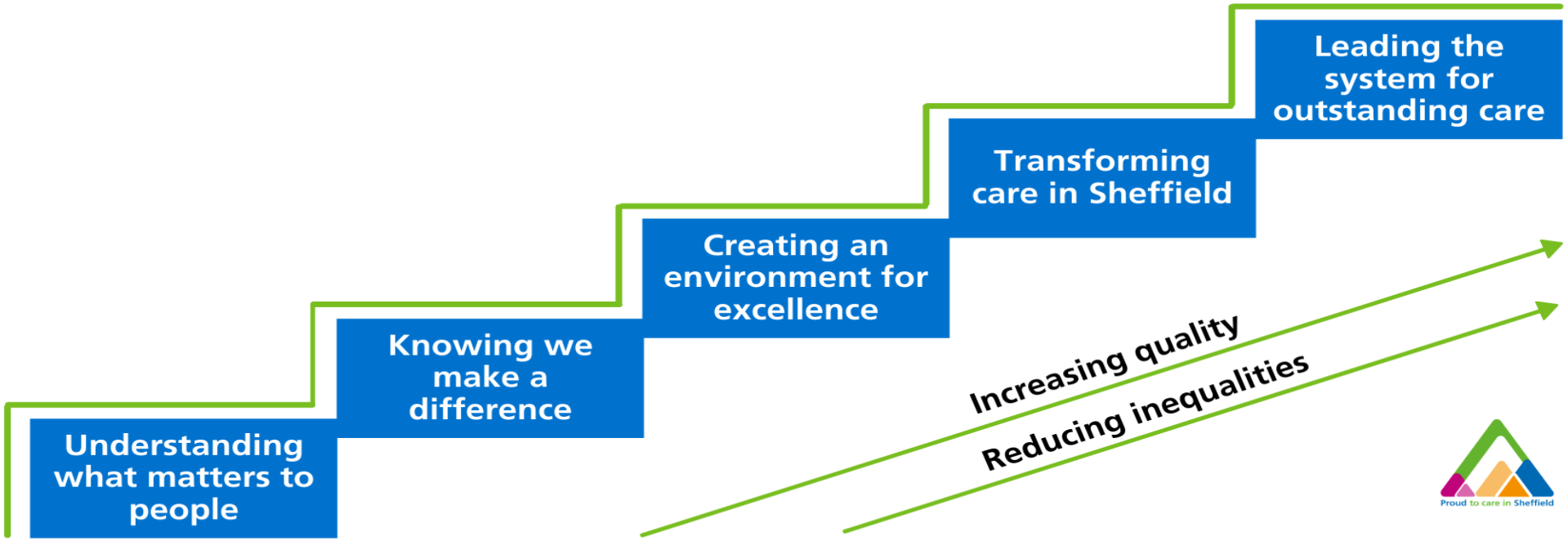
Clinical and Social Care Strategy: Five-Year Plan on a Page

Care that is:

Person-centred	Trauma informed	Evidence based	Strength based

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Primary Care	The City	The Wider System



Proud to care in Sheffield

Populating the Staircase

NHS Sheffield Health and Social Care NHS Foundation Trust

Understanding What Matters to People	Knowing We Make a Difference	Creating Environments for Excellence	Transforming Care in Sheffield	Leading the System for Outstanding Care
Minimal Restrictive Practice	A Person-Centred Outcomes Framework	Therapeutic Built Environments that Support Care Models	Community Partnership for Clinical, Social Care & Academic Excellence	Outstanding SHSC at the Forefront of SYB Quality Network
Meaningful Hospital Admission	Digital Systems to Capture Experience & Outcomes	Accredited Teams Across All Services	All Age Integration of Physical & Mental Health and Social Care	An Equitable Mental Health and Social Care System
Accessible Primary & Secondary Mental Health and Social Care	Measurable Consistency & Continuity in Care	Quality Networks Throughout SHSC	Zero Suicide Sheffield	Integrated Care from Neighbourhoods to System

Increasing Quality and Reducing Inequality

Proud to care in Sheffield

What are the Key Deliverables?

Understanding what matters to people

Improving access to effective services is key to our service users - we plan to deliver on this through the further expansion of IAPT (Increasing Access to Psychological Therapies) over the next year, providing evidence-led, person-centred therapies for people with mental health problems that include coping with Covid 19, early interventions for anxiety, depression, stress, and trauma.

Primary care transformation - integrated community models for adults with serious mental illness, “personality disorders” with a planned expansion to all 15-care networks. This will support the agenda to intervene early with an offer of care within the communities in which people feel familiar.

Further expansion of Perinatal services, including improving access to specialist community care from pre-conception to 24 months after birth, increased availability of evidence-based psychological therapies, access for partners and Maternity Outreach Clinics.

The crisis service is undergoing transformation to improve access by going to 24/7 care to provide alternatives to hospital inpatient admission.

We are undertaking a multidisciplinary piece of work to develop an improved therapeutic offer known as Purposeful Inpatient Admission for our inpatient wards.

We are mobilising a range of interventions, including the Safe Wards programme, to reduce restrictive interventions.

We aim to end out-of-area placements in 2021, subject to establishing a viable bed base during significant inpatient building works required on the grounds of patient safety.

Knowing we make a difference

We are committed to developing the required levels of digitisation and achieve data quality maturity within and across our clinical services that support clinical teams to deliver care that is based on real time and up to date information. We are developing a new Electronic Patient Record. We recognise that a strong digital infrastructure and capability will enable us to deliver high quality, safe service user care and the ability for our staff to work in a flexible and agile way.

We will develop a person-centred outcomes framework, building on existing measures such as the Health of the Nation Outcomes Scale (HoNOS), adding service user reported outcomes including Recovering Quality of Life (ReQoL). We will link outcomes with the aims of Collaborative Care Plans and ensure that outcomes are tailored to what matters to people.

We will track key indicators of wider impact, for example:

- Deaths by suspected suicide
- People with SMI in stable and appropriate accommodation
- Recovery targets in IAPT
- Rates of detention under the Mental Health Act, including according to ethnicity
- Smoking rates in people with a serious mental illness
- Homelessness
- Dementia recorded prevalence and place of death

In summary, we will know that we are succeeding if we are collecting and achieving good clinical outcomes for our service users and carers, which they report as meaningful, and achieved within services that are accessible and effective.

Creating environments for excellence

As part of SHSC's commitment to creating environments for excellence and having therapeutic environments that support care, we will develop environments that are safe, therapeutic, compassionate, enable best practice and provide the best for service users. These will be environments where people feel valued and listened to, and staff enjoy coming to work because they are supported to learn and develop together. This work will cover three main areas:

Physical Environment

There is an agreement with the Estates Directorate that all modernisation work to the physical estate will include co-production with service users and staff working into that area, as well as staff who are experts in transforming the physical environment via a creative approach, for example Arts in Health being a main contributor.

We will develop the Small Change – Big Impact approach to ask service users and staff what small changes they would like to make to the physical environment that could potentially have a big impact. For example, planted areas and artwork in reception/welcome areas.

Therapeutic Environment

We will lead on a range of developments that strengthen the therapeutic offer. This includes inpatient services having Allied Health Professional staff working flexibly to include evening and weekends and supporting the Therapeutic Activities Development Group to offer a range of meaningful activities across inpatient areas. We will support ideas into innovation, including developing a new, dedicated Recovery College that fits with existing activities at Sheffield Flourish and other community groups. We will engage Peer Support Workers as part of developing the therapeutic environment.

Great Place to Work

We will develop a positive workplace culture, working with Organisational Development to ask, 'What makes a great team?' and widely share learning. We will continue to develop the 'Health and Wellbeing' festival as well as the 'Joy at Work' initiative.

Transforming care in Sheffield

The Primary Care Mental Health Framework for Sheffield launched in July 2020 and within weeks they had seen and supported 600 people who would have neither accessed IAPT or secondary care mental health services (nearly 40% of whom were from BAME backgrounds).

- We have tested new models within four Primary Care Networks in Sheffield, accounting for 33% of Sheffield's population.
- We have recruited around 30 staff into roles ranging from clinical psychologists/psychotherapists; mental health nurses; occupational therapists; community connectors and health coaches. We have also piloted new NHS roles such as Clinical Associate Psychologists (CAPs) and Mental Health Pharmacists.
- Over 1600 individuals have been seen to date within the new models of mental health support, working to a 4-week waiting time target that is locally developed. (This is already significantly ahead of the planned trajectory of 855 patients being seen between June 2020 - March 2021).
- We are also working to support citywide work to improve access to, uptake of and behaviour change related support relating to SMI Physical Health Checks.
- We have been successful in investing with VCSE organisations to support wider social needs through social prescribing.

As part of the Clinical and Social Care Strategy we plan over the next 2 -3 years to build on the success of the 4 primary care networks and role this out to the remaining 11 primary care networks across Sheffield covering all 15 networks with the NHS LTP stipulating 50% matched funding from primary and secondary care.

What we expect to see in terms of specifics and measurable by 2025 are matched funded posts between primary and secondary care, integrated ways of working across the 15 primary care networks, and well-developed partnerships and integrated work with VCSE. We also expect a reduction in difficulties in reported access to mental health services, early intervention for people from BAME communities, reduction in health inequalities and improvements in reported quality and service user experience. We aim to align SHSC and its partners to a Zero Suicide Sheffield ambition and enabling programme.

The Primary Care Mental Health Programme is currently focussed on working age adults and older; our aim is to achieve all age working as part of delivering this Strategy.

Leading the system for outstanding care

We will adopt a stepped approach to developing quality networks for MHLDA. Firstly, within SHSC as part of our overall improvement plan. Secondly, within Sheffield, creating place-based quality networks for MHLDA and working with partners to improve outcomes across the City. Using this experience, we will build towards a system level MHLDA quality network, bringing benefits to the wider system and providing the quality platforms for system level programmes such as Provider Collaboratives.

We will work with the system to develop measures of experience and outcomes from neighbourhood to system level. We will also develop measures of assurance of equity for MHLDA in the system.

We will use our academic identity to facilitate Research and Innovation for MHLDA within the system. We are one of only three MHLDA Trusts in the Country to be members of the University Hospital Association. We are the only MHLDA Trust in Yorkshire and the Humber to achieve all our Key Performance Indicators for research set by the Clinical Research Network. We are the largest local recruiters of patients to interventional studies. We will use our experience to bring the same success in the wider system.

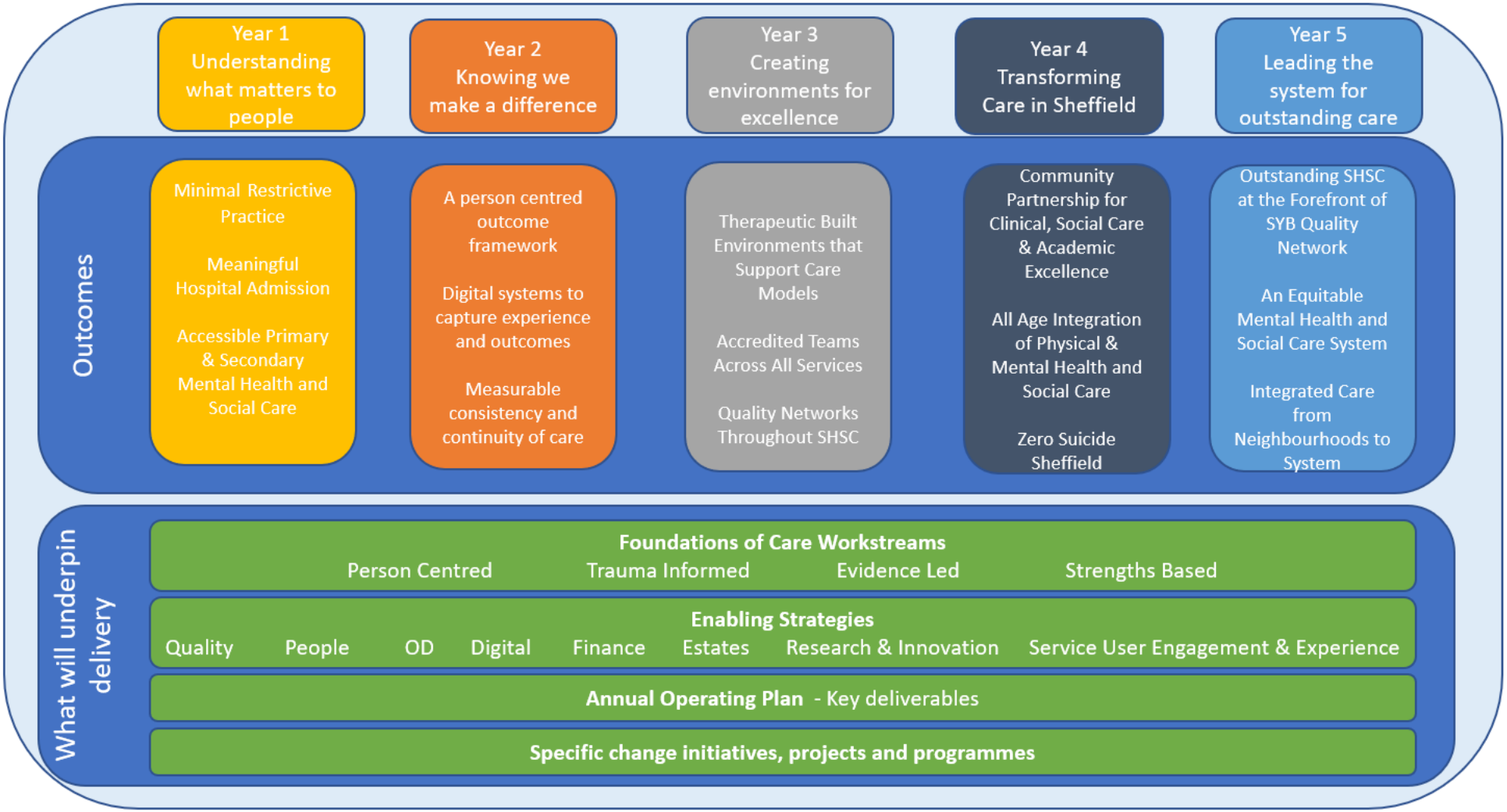
Implementation of the strategy

To promote the successful implementation of the strategy a programme of work has been initiated. The programme will form part of SHSC's Transformation Portfolio which contains the key transformation projects and programmes which will deliver our strategic aims; the governance and oversight of which is provided by the Transformation Board.

A roadmap has been developed which demonstrates the outcomes we wish to achieve over the next five years, the major steps to realise them and how they are unpinned by our enabling strategies, change initiatives and annual operating plan.

Workstreams based on the 4 Foundations of Care; person centred, trauma informed, evidence led, and strengths based will be established to ensure these core pillars remain central to the implementation of the strategy.

Clinical and Social Care Strategy



Key deliverables from enabling strategies

Table 1 outlines more of the detail from the key deliverables within the enabling strategies over the five-year Transformation programme, giving details of how the eight enabling strategies will work to support the delivery of the Clinical and Social Care Strategy in a coordinated framework.

Table 1 Clinical and Social Care Strategy – key deliverables from enabling strategies.

Clinical & Social Care Strategy		Estates Strategy	Digital Strategy	Organisational Development Strategy	Quality	Finance	Service User Engagement & Experience	Research & innovation	People Plan
Workstreams	**Key Requirement**	**Deliverables & Year**	**Deliverables & Year**	**Deliverables & Year**	**Deliverables & Year**	**Deliverables & Year**	**Deliverables & Year**	**Deliverables & Year**	**Deliverables & Year**
Person Centred	Define Personalised Care. Support service users to live full and independent lives - 2022	Privacy & dignity En-suite bathrooms - 2022 Spaces to conduct confidential activities – e.g., supervision - 2024	Digital staff record - 2022 EPR that promotes use of evidence based driven care - 2023	Develops culture of equality, respect, compassionate care - 2022 Develops our culture around psychological safety at all levels - 2023	Embed co-production with service users & carers in how we deliver and govern clinical services - 2023	Growth MHIS Financial support to embed what is needed re recovery from COVID - 2022	Co-production across teams and services - 2023	Outcomes: Implement ReQol - 2022	Skilled management of services that are delivered in a flexible way - 2023 Workforce that supports Trusts values & behaviour - 2023

Evidence Based	Define Using best available evidence -to inform treatment plans – 2023	Healing environment: New acute build - 2024 Green Plan delivering incremental improvements re utilities, waste, footprint exercise	Clinical outcome, patient experience and performance data fed back to teams in real time - 2023	Culture: promote a culture of learning and development - 2022	QI Support the robust evaluation of the clinical outcome data & advice on the changes needed – 2023	Capital New estate - 2025	Service user led outcome data – focus groups to ensure EbE/ peer led evaluation - 2023	Builds and increases our research capacity and outputs - 2023	Training: Ensure staff are up to date with new evidenced based practice – 2023
Trauma Informed	Define Recognise & respond to trauma. Provide safe environments take a strengths-based view. Build empowering relationships Promote equality of access - 2023	Reduce restrictive practices: Green Rooms - 2021 Enough consulting rooms and easy access to them to deliver care - 2023	An efficient, streamlined electronic patient record system that interacts seamlessly with those of our partner organisations - 2023 Fewer administrative tasks – 2023	Culture & Inclusivity: OD Plan that embeds the principles (trauma informed etc) into our systems of working, governance and decision making - 2022	Measurable reduction in the use of restrictive practices - 2023	Financial support for Digital solutions to promote efficient models of trauma informed care - 2023	Peer led psychosocial support across the system - 2023 Co- developed & led training for staff - 2022	Research That focuses on trauma informed care- addresses inequality /access to care - 2023	Training the whole system in Trauma informed care – 2023 Staff wellbeing initiatives promote Trauma informed frameworks of support - 2022
Strengths Based	Define Encourage use of personal resources, skills abilities knowledge & potential to protect choice and independence – 2022	Activity spaces: MCC gym - 2021 Agile working in new buildings- ensure some space for meetings / social connections	Effective WIFI A digital infrastructure that works everywhere fast /reliable Digital solutions that enable self-care, remote working and responsive access to support & care - 2023	Leadership Develops culture of self-led teams - 2023	Governance systems that are focussed on understanding and improving quality - 2023	Embeds resource effect strengths-based models of care - 2023	Development of Peer roles across the clinical systems to encourage strengths-based approach to care – 2023	Embeds research driven care into day-to-day practice - 2024	Workforce represents community active promotion to address inequalities in senior posts – 2023

Programme Definition Plan

A detailed plan to define the programme implementation has been produced; the key milestones are documented below.

Milestone	Owner	Completion Date
Initial engagement activities to co-produce the implementation plan complete.	Linda Wilkinson	August 2021
Workstream development complete including appointing leads and developing individual plans.	Linda Wilkinson / PMO	August 2021
Engagement and alignment with existing initiatives and changes complete.	Workstream Leads	August 2021
Requirements defined from enabling strategies and operating plan.	Workstream Leads	August 2021

The programme definition plan can be found in Appendix 1.

The programme milestone plan can be found in Appendix 2.

In summary

We have worked with service users, carers, colleagues in SHSC and partners across Sheffield to coproduce the Clinical and Social Care Strategy. In doing so, we have established these foundations Person-Centred, Strengths-Based, Trauma-Informed and Evidence-Led as principles for care that will inform our approach in different contexts, ranging from Primary Care to the Wider System.

Throughout, the aim is simple, which is to improve the quality of care that our service users receive at the same time as reducing health inequalities that adversely impact on many.

The Clinical and Social Care Strategy sets out a 5-year map to use the foundation principles of care to support strategic priorities ranging from Understanding What Matters to People, to Leading the System for Outstanding Care. The strategy will inform other strategic developments and be supported by enabling strategies, outlined within the implementation plan.

The summary of the programme definition plan and the milestone plan outline that we are ready to work collectively and at pace to make the improvements to quality of care and use this as a platform to address the inequalities outlined in the strategy.

The range of influence in the Clinical and Social Care Strategy is broad and sets high standards. If we were to sum up the Clinical and Social Strategy in a single phrase, then perhaps we should borrow from the values of the NHS Constitution and simply say ‘everyone counts’.

Appendix 1: Clinical & Social Care Strategy - Programme Definition Plan

1. Resources

Task	Ref	Owner	Status	Timeframe - Start	Timeframe - End	Progress
Review membership of steering group	1.1	Linda Wilkinson / Mike Hunter	Done	06/07/2021	09/07/2021	100.00%
Draft ToR of Programme Board	1.2	Zoe Sibeko / Abbi Johnson	On Track	19/07/2021	23/07/2021	0%
Identify Programme Team	1.3	Linda Wilkinson	On Track	12/07/2021	23/07/2021	0%
Agree roles and responsibilities of Programme Team	1.4	Linda Wilkinson	On Track	26/07/2021	30/07/2021	0%
Identify resource requirements	1.5	Mike Hunter	Done	09/07/2021	09/07/2021	100%
Recruitment activities	1.6	Zoe Sibeko	Not Started	02/08/2021	31/08/2021	0%
Business case / sign-off governance for Programme Manager	1.7	Zoe Sibeko	Not Started	02/08/2021	30/09/2021	0%
				06/07/2021	**30/09/2021**	**14%**

2. Engagement Activities

Task	Ref	Owner	Status	Timeframe - Start	Timeframe - End	Progress
Establish service-user reference group	2.1	Linda Wilkinson / Jo Hemmingfield	On Track	09/07/2021	31/08/2021	0%
Engage with experience and engagement team to ensure co-produced plan	2.2	Linda Wilkinson / Jo Hemmingfield	On Track	09/07/2021	31/08/2021	0%
				09/07/2021	**31/08/2021**	**0%**

3. Workstream Development

Task	Ref	Owner	Status	Timeframe - Start	Timeframe - End	Progress
Identify workstream leads	3.1	Linda Wilkinson / Mike Hunter	Done	12/07/2021	16/07/2021	100%
Define workstream teams	3.2	Zoe Sibeko / Abbi Johnson	Not Started	02/08/2021	31/08/2021	0%
Develop individual plans	3.3	Zoe Sibeko / Abbi Johnson	Not Started	02/08/2021	31/08/2021	0%
				12/07/2021	**31/08/2021**	**33%**

4. Initiatives and Changes

Task	Ref	Owner	Status	Timeframe - Start	Timeframe - End	Progress
Engage with the clinical lead regarding the minimal use restrictive practice plan	4.1	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the clinical lead regarding meaningful hospital admission	4.2	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the operational lead regarding the community service review	4.3	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the operational lead regarding SPA and EWS	4.4	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the operational lead regarding Core 24	4.5	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the clinical lead regarding the at-risk mental health pathways	4.6	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the operational lead regarding the expansion on IAPT services	4.7	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the SRO regarding the primary care transformation programme	4.8	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
Engage with the Programme Director regarding the adult and forensic new care models programme	4.9	Linda Wilkinson / Workstream Leads	On Track	01/06/2021	31/08/2021	0%
				01/06/2021	**31/08/2021**	**0%**

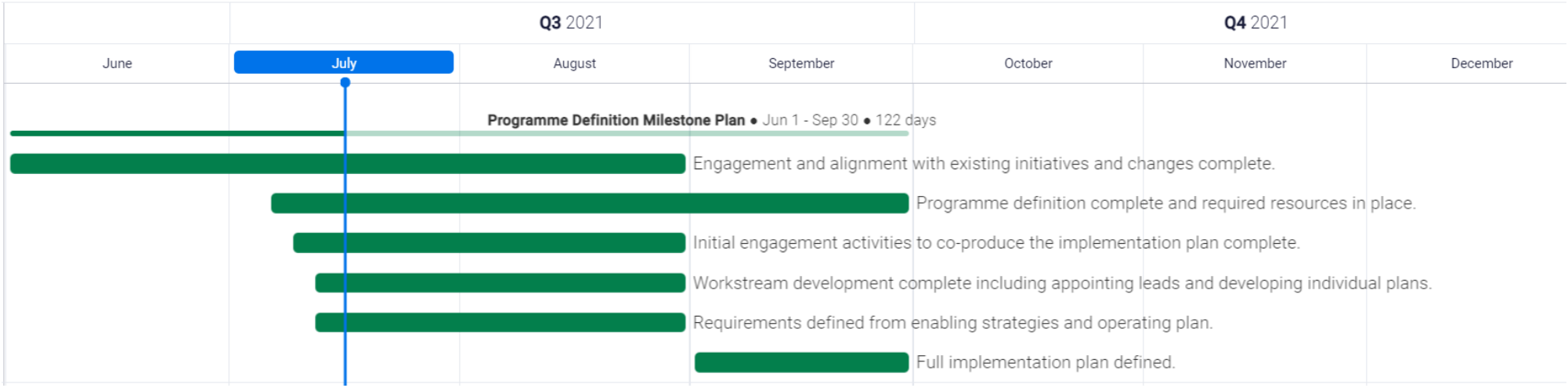
5. Enabling Strategies

Task	Ref	Owner	Status	Timeframe - Start	Timeframe - End	Progress
Agree requirements with Quality Strategy lead	5.1	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
Agree requirements with People Strategy lead	5.2	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
Agree requirements with OD Strategy lead	5.3	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
Agree requirements with Digital Strategy lead	5.4	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
Agree requirements with Finance Strategy lead	5.5	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
Agree requirements with Estates Strategy lead	5.6	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
Agree requirements with Research Strategy lead	5.7	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
				12/07/2021	**31/08/2021**	**0%**

6. Operating Plan

Task	Ref	Owner	Status	Timeframe - Start	Timeframe - End	Progress
Understand key deliverables from the operating plan	6.1	Linda Wilkson / Zoe Sibeko	On Track	12/07/2021	31/08/2021	0%
				12/07/2021	**31/08/2021**	**0%**

7. Define Implementation Plan

Task	Ref	Owner	Status	Timeframe - Start	Timeframe - End	Progress
Define implementation plan	7.1	Zoe Sibeko / Abbi Johnson	Not Started	01/09/2021	30/09/2021	0%
Endorse draft implementation plan with Programme Board	7.2	Zoe Sibeko / Abbi Johnson	Not Started	01/09/2021	30/09/2021	0%
Consult with stakeholders (service users, staff groups, teams etc.) on the draft implementation plan	7.3	Zoe Sibeko / Abbi Johnson	Not Started	01/09/2021	30/09/2021	0%
Approval of plan at Programme Board	7.4	Zoe Sibeko / Abbi Johnson	Not Started	01/09/2021	30/09/2021	0%
Endorsement of plan at Transformation Board	7.5	Zoe Sibeko / Abbi Johnson	Not Started	01/09/2021	30/09/2021	0%
Review of plan at Trust Board	7.6	Mike Hunter	Not Started	01/09/2021	30/09/2021	0%
				01/09/2021	**30/09/2021**	**0%**

Appendix 2:
Clinical & Social Care Strategy - Programme Definition Milestone Plan